

# Coping with a medical malpractice suit

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## INTRODUCTION

In this article, I discuss how and why physicians react to an accusation of malpractice and the range of strategies that they can use to diminish the emotional disequilibrium that accompanies this experience. Information presented here is based on survey and interview studies and extensive clinical experience.

Medical work is highly stressful, and physicians increasingly feel loss of control over their clinical decision making. Nonetheless, most physicians are competent and achieve a reasonable level of satisfaction in their personal and professional lives that serves as good preparation for managing the litigation experience (box 1). Physicians are especially challenged, however, when an unexpected outcome—such as an unanticipated death—occurs. If this event is followed by a charge of malpractice, they may feel suddenly overwhelmed and “out of control,” with their ability to function temporarily compromised.

## REACTIONS TO BEING SUED

The reaction to being sued often is prefaced by a period of emotional turmoil following the catastrophic event or negative outcome. The physician may feel unduly responsible or guilty, genuine sorrow for the persons involved, dread, anxiety, and fear of being sued. These feelings may not resolve in any way until the statute of limitations expires or a suit is filed.

### Before the complaint: useful attributes of clinicians

- Competent practice, including good risk-management procedures
- Adequate self-knowledge
- A balanced personal and professional life
- A capacity for intimacy and sharing
- Good relationships with patients, their families, and other health professionals

More than 95% of physicians react to being sued by experiencing periods of emotional distress during all or portions of the lengthy process of litigation.<sup>1</sup> This may begin immediately on being served with the complaint by a sense of outrage, shock, or dread about the personal and financial effects of the eventual outcome. This is the first reaction in a series that is similar to those that accompany any major life event (box 2).<sup>2</sup> Feelings of intense anger, frustration, inner tension, and insomnia are frequent throughout this period.

Symptoms of major depressive disorder (prevalence, 27%-39%), adjustment disorder (20%-53%), and the onset or exacerbation of a physical illness (2%-15%) occur, although fewer than 2% acknowledge drug or alcohol

### Common postcomplaint experiences

- Symptoms may develop during any of these stages when adequate coping fails
- The complaint is served: initial feelings of surprise, shock, outrage, anxiety, or dread
- Consultation with lawyer: depending on the initial assessment of the case, reactions of anger, denial, concern, reassurance, panic
- Lengthy period of denials and intrusions: active attempts to erase thoughts about the case, followed by automatic reminders and intrusive thoughts about it; becoming preoccupied by ruminating excessively—exacerbated whenever case-related activity increases, such as before the deposition, when experts testify, and before and during the trial
- Working through the lengthy process, during which physicians psychologically and intellectually “process” the meaning of the case, their role in it, and their approach to their own defense
- Relative completion of response: physicians change in many ways as a result of being sued; ideally, adaptations lead to greater competence and a more satisfying personal and professional life

### Summary points

- Periods of emotional disequilibrium wax and wane during the lengthy litigation process
- The central psychological event of litigation is the accusation of having failed to meet the standard of care
- To counteract the common feelings of loss of control, physicians can seek emotional support from trustworthy family or friends, work to master their personal and professional lives, and understand that compensation—not competence—lies at the heart of malpractice law
- Rapid interventions aimed at reducing the effects of stress will decrease disability, restore self-esteem, diminish risk for future claims, and enable physicians to be “good” defendants
- Most sued physicians are eventually vindicated

misuse.<sup>1,3,4</sup> A general internist, for example, described awakening with his first episode of atrial fibrillation after being served with his first malpractice suit the previous afternoon. This generated emergency medical consultation accompanied by profound psychological effects on the physician. Some 2 years later, it figured prominently in his decision to settle and to retire earlier than he had originally planned.

## WHY DO PHYSICIANS REACT?

The more clearly we identify the sources of stress specific to our own case, the better able we are to cope effectively. Lawyers and insurers often advise: “Don’t take this accusation personally; it is just the cost of doing business.” Although each lawsuit—its participants, the nature of the injury, and particular circumstances—is unique, physicians share common feelings and reactions.

These reactions are related to 2 major factors: the personality characteristics of physicians and the nature of tort law. Physicians

## Stages in the litigation process

### The complaint

- The charge detailing what the physician allegedly did or failed to do to cause the injury; may be proceeded or followed by public notice

### Discovery

- Interrogation: written questions regarding facts that are thought relevant
- Depositions: oral testimony under oath that may be used in court proceedings
- Expert witnesses: testimony is established that offers opinions by both sides related to the facts of the case and their relevance to the standard of care

### Trial

- Settlement: a series of pretrial maneuvers that may lead to a resolution of the case by a monetary or some other agreement
- Trial: a procedure governed by a set of rules that allows each side to argue their view of the case
- Verdict: decision by either judge or jury

### Appeal

- Not a retrial
- The losing side may request a review of the trial record to ascertain if it met the letter and intent of the law

the nature of the patient's injury, and the amount of surrounding publicity, all play a role in generating stress. Last, litigation is intrinsically adversarial and creates an environment foreign to that in which most physicians work. This contributes to feelings of isolation, frustration, and dependency that threaten their usual feelings of equilibrium.

## COPING WITH LITIGATION

The first step in coping is to obtain an adequate knowledge base about what can be anticipated psychologically and about the process in which the physician is now a participant, albeit an unwilling one (boxes 2 and 3).

Second, throughout the entire process, physicians need to observe their emotional and physical reactions. If they do not have a personal physician, they should get one. If persistent symptoms of any kind—physical illness, depression, or substance misuse—occur, they should consult their physician. Physicians should not self-medicate even when bothered by the common symptom of insomnia. They also need to observe if their relationships with family or in their professional life have changed and take the appropriate steps to remedy these.

A feeling of being out of control pervades

the litigation experience. Coping is a complex process in which regaining mastery is central. Clinical experience reveals that if physicians are shown strategies that they can apply “in their own way,” regaining mastery by their own efforts, then they feel better about themselves. Ideally, the more rapidly this is achieved, the better because chronic stress can lead to further disability. Rapid restoration of emotional equilibrium is suggested as a way of reducing further risk because risk for an additional claim doubles for physicians who have had a claim in the previous year.<sup>6</sup>

These findings suggest that emotionally stressful events may play a role in a physician's vulnerability to being involved in critical claim incidents. A personal event, such as marital discord or practice disruptions, can occur both before and after such an incident, and the claim itself may be so psychologically disruptive that the physician changes in ways that affect his or her vulnerability to critical incidents.

Useful coping strategies can be conceptualized in 3 categories<sup>7</sup> (box 4).

## Social support

As with any major life event, physicians need to share their feelings and reactions with someone who is trustworthy, understanding,

are self-critical and, therefore, have a tendency to doubt themselves, be vulnerable to feelings of guilt, and to possess an exaggerated sense of responsibility.<sup>5</sup> These personality features render them particularly vulnerable to the demands of tort law because fault must be established for compensation to be paid. In medical malpractice law, fault is based on a deviation from the standard of care that resulted in the injury. As a group, physicians are acutely sensitive to any suggestion that they have failed to meet the standard of care or are not “good” doctors. Their honor—that sense of personal integrity that most people cherish—is at issue, and the threat of its loss is devastating. This accusation of failure represents a personal assault: the central psychological event that generates the stress that gives rise to the symptoms and reactions described.

Other factors unique to each case, such as the physician's relationship with the patient,



Physicians who are sued feel accused of having failed

### Some strategies for coping with litigation

#### Social support

- Discuss your feelings with a trusted person—your lawyer, another physician, a family member, or a friend
- If the above are unavailable, contact your local medical or specialty society for referral to an available peer or support group

#### Restore mastery and self-esteem

- Ask your lawyer to describe your role in each step of the process
- Ask about the anticipated length of time required to process the case
- Make sure you feel comfortable with your appointed lawyer and request a change, if necessary
- Determine the usefulness of retaining a personal lawyer
- Participate in choosing your experts
- Prepare yourself for the unpredictability of the process—the rules, the lawyers, the judge, the experts, and the jury
- Take an active role with your lawyers in the defense of the case
- Identify areas of practice that cause anxiety or feelings of “loss of control” and find ways to diminish them
- Do not participate in practice situations that demand compromises in your professional standards
- Engage in activities that will increase your competence: courses, accreditation activities, teaching, or hospital or clinic committee work
- Review the amount of time you devote to family and professional activities and make the necessary changes
- Attend to financial and estate planning, if this has been long delayed
- Take time away from practice, such as a non-tax-deductible vacation
- Participate regularly in active sports, workouts, or other leisure activities
- Schedule the necessary preparation time for depositions and participation in the trial
- Do not try to “fit patients in” during the trial; being on trial is a fulltime job

#### Change the meaning of the event

- The charge is that you have failed in competence and are, therefore, a “bad” doctor; you therefore need to work to perceive yourself as “good”
- Review your career objectively: most physicians function well and with competence
- Reflect on the input of legal and insurance counsel about the case and work to acknowledge the “truth” about the events in question
- Seek trustworthy consultation with family and professionals about the effects of settlement and/or going to trial
- Be kind to yourself, even when being objective

and sensitive to their concerns during what is, for some, the most stressful period of their entire life.<sup>8</sup> Legal counsel will advise not to talk about the details of the case to anyone. This is good legal advice, based on fears that the physician may say something that will potentially jeopardize the case. It is not, however, good psychological advice. Most of us can derive comfort confiding in an associate, legal counsel, our spouse, office staff, or a respected senior physician, all of whom can appreciate the concerns of legal counsel.

#### Restoring mastery

The entire process challenges physicians’ feelings of mastery as it seeks to establish who was in control of, and therefore, responsible for, the events in question. Sued physicians often experience a “see-saw effect”: up 1 week and down another with alternating feelings of confidence and low self-esteem, of assurance and doubt. They may not be able to control the pace or even the outcome of their case, but engaging in activities that make them feel in better control of both their personal and

professional lives and participating actively in their defense will help restore their sense of balance.

#### Changing the meaning of the event

The malpractice charge suggests that we are incompetent and, therefore, “bad doctors.” We need to change this perception and to develop inner peace and good feelings about ourselves. It helps to recognize that litigation is about compensation, not competence, that those who are sued are often the best in their field in working with sick and high-risk patients, and that most physicians are eventually vindicated.

#### CONCLUSIONS

An understanding of litigation stress and some anticipation of its potential psychological effects on physicians enable them to take steps to counteract the negative feelings and reactions that occur. The goal is to understand and diminish the effects of stress and regain a sense of emotional equilibrium to function as a good defendant and competent practitioner during the lengthy litigation process.

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#### Resources for dealing with medical malpractice litigation

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## Physicians' feelings: toward a balance in medical education

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Imagine you are assisting during an operation. The surgeon is having difficulty tying off a bleeding artery. His brow is sweating and hands are taut as he requests a clamp. The surgeon is handed an incorrect instrument and flings it across the floor, demanding the correct tool. The scrub tech explains that the desired clamp is not sterile. The surgeon yells and throws the instrument tray on the floor. The operating room becomes completely silent. The surgeon regains control, mutters a slight apology, asks for any sterile clamp, and proceeds. He is known as a caring physician, and discussion about his temper never ensues. His behavior remains accepted.

Now imagine you are a medical student participating in a surgical case where resuscitation efforts, including cracking open the patient's chest, fail. As the surgical team leaves, the attending physician instructs 2 medical students to practice suturing by repairing the man's chest for his family. Everyone exits, leaving the students to their task without further discussion. The students cope through irreverent humor and forever share a bond created through this awkward moment.

Next imagine you are a medical intern on call at an understaffed hospital. The patients are extremely sick, and getting orders completed is difficult. Critical laboratory tests are often reported a day late. Patients die daily. Many patients have terminal diseases, are in great pain, or are severely demented. Conversation in the team room mirrors that in a locker room—filled with derogatory cracks about patients, the system, other house staff, and consultants. This humor, plus a lot of caffeine, helps the team make it through the night.

Each of these stories is true. The first happened 13 years ago, and the other 2 occurred this past year. Emotions in medicine are challenging and frequently ignored. Do you remember a colleague in training or practice who attempted suicide, drank too much, or abused drugs? Are we trained to help our colleagues or ourselves? Medicine is rife with emotions, including joy, sorrow, hope, and angst. To promote both personal and professional well-being, we need to address the emotional experiences of physicians.

Academic medical centers can help by heeding the following principals:

### • To create humane physicians, we must treat trainees humanely

Edmund Pellegrino in 1974 put it succinctly: a humanist physician is the product of humanistic training.<sup>1</sup> Yet, medical training today is far from this ideal, and evidence exists that it often is outright abusive.<sup>2-5</sup> Reforms must encourage students to talk about their abusive or stressful experiences. Support groups and retreats are one forum for discussing these events.<sup>6-9</sup> Alternative techniques such as yoga and meditation offer relief from certain stresses.<sup>10,11</sup> Some hospitals support their house staff by limiting work hours and patient loads.<sup>12</sup>

One medical residency program in Rochester, NY, implemented comprehensive reforms to support humanistic values.<sup>13</sup> These focused on respect and shared vulnerabilities by having faculty model these behaviors. They also promoted time for reflection and relationships with mentors. The process toward humane training has begun but needs further refinement and expansion to reach more trainees.

### • The teacher-learner relationship and the doctor-patient relationship are parallel processes

The concept that the teacher-learner relationship reflects what occurs between physicians and patients is not new.<sup>14</sup> Both relationships involve members with unequal knowledge and power. Teachers and physicians have specific knowledge to impart. Teachers have power over evaluations and early career paths of learners. Physicians have power over patients through the distribution of medications, technologic interventions, and access to consultants. These unequal dynamics leave learners and patients vulnerable and even fearful. Both relationships work best when there is mutual respect, good communication, and agenda setting.

The beauty of the parallel process in medical education is that if the teacher-learner relationship is built on positive traits, the learners can apply these skills as physicians with their patients. Markakis et al described a study in which second-year medical students who felt supported by their teachers scored higher on humanistic test scores and assessment of patient-centered interviewing skills than fellow second-year students who felt controlled by their teacher. They concluded that "students who had their psychological needs for learning met were in turn more supportive of their patient's psychological needs."<sup>15</sup> This study supports investing in the teacher-learner relationship to enhance patient care.

### • Medical trainees can develop skills in self-awareness through reflection

Although self-awareness by its nature is individualistic, it can be promoted through curricular interventions and group processes.<sup>15,16</sup> Practitioners who are aware of how their actions affect patients, staff, and colleagues can help make health care more effective. There must be times during the fast pace of learning the art and science of medicine and delivering care when trainees can slow down to address their inner thoughts and feelings.

Energy invested in these 3 educational concepts can help physicians strive toward emotionally balanced careers. Addressing physicians' feelings early on in training may improve rates of career and patient satisfaction and decrease rates of physician impairment and malpractice claims. It is hoped that curriculum reforms in the 21st century will rise to meet this challenge.

References are available on our web site ([www.ewjm.com](http://www.ewjm.com)).